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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

NYSA-ILA WELFARE FUND, by its Trustees, JOHN BOWERS, ALBERT CERNADAS, FRANK LONARDO, THOMAS POPOLA, JAMES CAPO, JOSEPH N. BARBERA, BART DiMATTINA, and RICHARD H. O'NEILL,

Petitioner,

v.

FRANCIS J. DUNSTON, in her capacity as New Jersey Commissioner of Health; NEW JERSEY STATE DEPARTMENT OF HEALTH; NEW JERSEY HOSPITAL RATE SETTING COMMISSION; AND COLUMBUS HOSPITAL, EAST ORANGE GENERAL HOSPITAL, ST. JAMES HOSPITAL, and UNIVERSITY HOSPITAL, individually and as Class Representatives of Hospitals in the State of New Jersey; and NEW JERSEY HOSPITAL ASSOCIATION, as Class Representative of Hospitals in the State of New Jersey,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTIONS PRESENTED FOR REVIEW

1. Does the Employee Retirement Income Security Act ("ERISA") pre-empt a state healthcare statute that (i) deliberately shifts onto ERISA plans the cost of care provided to persons not covered by the plans and the cost of rate discounts provided to preferred insurers, (ii) increases the costs incurred by ERISA plans for hospital services to their beneficiaries by more than one-third, (iii) cannot function without the enforced participation of ERISA plans, and (iv) by express reference to ERISA plan beneficiaries deprives them of appeal rights enjoyed by others?

2. Does a state healthcare system that requires certain private welfare plans to pay for the hospital costs of the indigent and for mandatory discounts to certain favored insurers constitute a taking of private property without compensation in violation of the Fifth Amendment to the Constitution of the United States where

- the system increases the plans' hospital costs by more than 33⅓%
- the only benefit received by the plans and their participants is the continued existence of hospitals in the state, which confers no special benefit beyond that enjoyed by the general public;
- in establishing and funding the plans through collective bargaining, management and labor invested in welfare plans assets available for labor costs on the expectation that the broad ERISA pre-emption clause would protect the assets from state poaching; and
- matching federal funds received by the state based upon amounts paid by the plans for the indigent are not refunded to the plans or put into the healthcare system but are deposited into the state's general treasury?

PARTIES TO THE PROCEEDINGS

All parties in the court of appeals appear in the caption of this petition except parties in other cases that were consolidated with this action. In accordance with Sup. Ct. Rule 14.1(b) the names of all parties in the consolidated cases appear in the caption of the opinion of the court of appeals, which is reproduced in the separately bound appendix to this petition. It is also noted that, pursuant to Sup. Ct. Rule 12.4, all parties to the proceeding in the court whose judgment is sought to be reviewed shall be deemed parties in this Court, unless petitioner notifies the clerk of this Court of the petitioner's belief that a party below has no interest in the outcome of the petition. Petitioner has no knowledge of any uninterested party. In accordance with Sup. Ct. Rule 29.1, petitioner states that it does not have a corporate parent, subsidiary, or affiliate.

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INTRODUCTION

The NYSA-ILA Welfare Fund ("Welfare Fund") and other employee welfare benefit plans protected by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992), became the targets of a deliberate scheme

by the State of New Jersey to force these plans to do that which ERISA prohibits: use their funds for the benefit of persons who are not plan beneficiaries. Under the guise of a neutral law of general application fixing hospital rates the State of New Jersey actually adopted and implemented an elaborate cost-shifting scheme under which ERISA plans and their beneficiaries were forced by state law to use plan assets to finance the cost of hospital care provided to the indigent and to subsidize discounts provided to certain preferred insurers. The district court concluded that ERISA pre-empted application of this cost-shifting scheme. Despite the magnitude of the cost-shifts and their use to defray expenses of state programs from which ERISA plans and their beneficiaries derived no special benefit, the district court held that the cost-shifts were not a taking violative of the Fifth Amendment to the Constitution of the United States. A divided panel of the court of appeals reversed the pre-emption ruling and affirmed the Taking Clause determination. The Welfare Fund urges this Court to review the circuit court's decision.

OPINIONS BELOW

The judgment and opinion of the court of appeals, which is unofficially reported at 61 U.S.L.W. 2723 (3d Cir. May 14, 1993), are reproduced in the separately bound appendix to this petition (1a-61a).[1] The unreported opinion and order of the court of appeals sur petition for rehearing *en banc* (62a-63a) and the opinion and order of the United States District Court for the District of New Jersey (64a-95a), which is reported at 793 F. Supp. 524 (D.N.J. 1992), are also reproduced in the appendix.

JURISDICTION

The judgment of the court of appeals was entered on May 14, 1993. Thereafter the court of appeals denied a petition for rehearing by order dated June 15, 1993. This petition is filed within 90 days of both dates. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1988).

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[1] References are to the pages of the appendix.

CONSTITUTIONAL PROVISION AND STATUTE INVOLVED

1. The Fifth Amendment to the Constitution of the United States provides in relevant part:

> nor shall private property be taken for public use, without just compensation.

2. The relevant statutory provision is ERISA § 514(a), 29 U.S.C. § 1144(a) (1988):

> **(a) Supersedure; effective date.**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

STATEMENT OF THE CASE

A. Employee Retirement Income Security Act

In 1974 Congress enacted ERISA, a comprehensive regime to protect the interests of employees and their beneficiaries in employee benefit plans. ERISA's "crowning achievement" was the elimination of state regulation of employee benefit plans. *See Shaw v. Delta Air Lines,* 463 U.S. 85, 100 (1983). Congress fostered this objective by enacting a broadly worded pre-emption clause, ERISA § 514(a), which provides that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a) (1988). Lest there be any doubt, Congress also broadly defined the term "state law" to include all laws, decisions, rules, regulations, or other state action having the effect of law and the term "state" to include any political subdivision, agency, or instrumentality. 29 U.S.C. §§ 1144(c)(1), 1144(c)(2) (1988).

The function of federal pre-emption is to give effect to the "full purposes and objectives" of federal legislation, *see Hines v. Davidowitz,* 312 U.S. 52, 67-68 (1941), since under the Supremacy Clause of the Constitution of the United States federal law is "the supreme Law of the Land" to which "any Thing in the Constitution or Laws of any State to the Contrary" must yield. U.S. CONST. art. VI, cl. 2. When Congress adopts a broadly worded pre-emption provision, the "task of discerning congressional intent is considerably simplified." *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 138 (1990).

Previous decisions of this Court have described ERISA's express pre-emption provision as "conspicuous for its breadth," *FMC Corp. v. Holliday,* 498 U.S. 52, 58 (1990), "virtually unique," *Franchise Tax Board v. Construction Laborers Vacation Trust,* 463 U.S. 1, 25 n.26 (1983), and "designed to establish pension plan regulation as exclusively a federal concern." *Ingersoll-Rand,* 498 U.S at 138. The clear and unambiguous congressional intent of expansive pre-emption is manifested not only in the explicit language of ERISA's pre-emption clause itself but in the historical record of its legislative passage.

> The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's pre-emptive scope was as broad as its language.

Shaw, 463 U.S. at 98.

ERISA's pre-emption provision has generated a wealth of decisional law, reflecting the efforts of the lower courts to plot the outer limits of ERISA's pre-emptive reach. This Court has visited the provision with unusual frequency, and it is evident from the import of its most recent decisions that it has had to do so in order to protect ERISA pre-emption from improper limits on its metes and bounds that lower federal courts have sought to impose. *See Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133 (1990); *FMC Corp. v. Holliday,* 498 U.S. 52 (1990); *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts,* 471

U.S. 724 (1985); *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

The focus of these visitations has centered on the meaning and scope of the phrase "relate to," which was chosen by Congress as the controlling standard. This Court has consistently protected the ERISA pre-emption provision from erosion by lower courts' narrowing of the term "relate to." The "relate to" standard must be interpreted expansively, *see Shaw*, 463 U.S. at 98, and must be given "a broad common sense meaning," see *Ingersoll-Rand*, 498 U.S. at 139. Indeed, the controlling test for determining whether a state law meets the "relate to" standard is simple and direct: every state law that has a connection with or reference to an ERISA employee benefit plan relates to that plan and is pre-empted. *FMC Corp.*, 498 U.S. at 58-59; *Shaw*, 463 U.S. at 96-97. Pre-emption occurs even if the connection, reference, or effect is only indirect. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. ____, 113 S. Ct. 580, 583 (1992); *Ingersoll-Rand*, 498 U.S. at 139; *Pilot Life*, 481 U.S. at 47. Only where the connection is "tenuous, remote or peripheral" is pre-emption avoided. *Shaw*, 463 U.S. at 100 n.21.

B. Facts of This Case

1. New Jersey's Hospital Rate-Setting Regime

A highly socialized system for regulating hospital rates evolved in the State of New Jersey. It had its modest beginnings in 1971, when New Jersey enacted the Health Care Facilities Planning Act, N.J. Laws 1971, ch. 136, § 18, a legislative authorization for collectivized rate-setting limited at first to patients insured by Blue Cross and Blue Shield of New Jersey (hereinafter "Blue Cross") or entitled to benefits from certain federally funded programs, like Medicare and Medicaid (20a; 66a). Seven years later the limitations were removed, and the State of New Jersey embarked on a full-fledged, comprehensive hospital rate-setting scheme that mandated fixed rates for all (66a). *See* N.J. Stat. Ann. §§ 26:2H-1—26:2H-52 (West 1987 & Supp. 1992); N.J. Admin. Code, tit. 8, ch. 31B (Supp. 1990).

2. Cost-Shifts

The State of New Jersey made a conscious and deliberate decision to impose disproportionately on ERISA plans and their

beneficiaries certain social welfare costs associated with hospital care in the state (34a; 37a; 43a). The New Jersey hospital rate-setting statute and regulations required hospitals to add to the basic rate[2] surcharges to pay for uncompensated hospital care, the "Medicare Cost-Shift," and discounts granted to certain preferred insurers. ERISA plans and their participants bore the lion's share of these surcharges (37a).

a. Uncompensated Care Surcharge

New Jersey hospitals are mandated by state law to admit every patient seeking treatment regardless of ability to pay (20a; 68a). Uncompensated care consists of costs incurred to provide hospital care to uninsured, indigent patients not covered by Medicare or Medicaid. All New Jersey hospitals were required to add to the applicable DRG rate an uncompensated care surcharge of 19% (34a; 68a), which was transmitted to the state-administered New Jersey Health Care Trust Fund, from which it was redistributed to hospitals statewide according to need (68a), *see* N.J. Stat. Ann. §§ 26:2H-18.7 18.14 (West Supp. 1992).

The uncompensated care program not only enabled New Jersey to insulate its state treasury from responsibility for indigent care but also provided the state with an ingenious windfall. New Jersey received federal matching funds for amounts collected by the Health Care Trust Fund. These federal monies, however, never found their way into the Trust Fund. They were intercepted and deposited in the general treasury of the state to be used for other purposes unrelated to healthcare.

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[2] Hospital rates were based not on the actual cost of the inpatient treatment received by the patient from the particular treating hospital but on a blended, statewide average cost normally incurred to treat the particular illness or condition (20a; 34a; 67a). An elaborate taxonomic system classified diseases into more than 740 categories, known as Diagnostic Related Groups or "DRG's," *see* N.J. Admin. Code, tit. 8, ch. 31B, § 5.3 (Supp. 1990). Each DRG for each hospital in the state was assigned a rate which was the weighted average of the cost incurred by that specific hospital and the average cost incurred by all hospitals in the state to treat that particular DRG condition (20a; 67a). The costs taken into account included both direct costs, such as salaries and fringe benefits provided to hospital employees engaged in the direct delivery of patient care, and indirect costs, such as institutional overhead expenses for management, research, education, and maintenance (41a; 67a). The DRG system itself is not at issue in the litigation (20a).

b. Medicare Cost Shift

The DRG rate was increased by an additional add-on to compensate hospitals for shortfalls caused by the Medicare Cost Shift. Hospitals treating Medicare patients received reimbursement at rates invariably less than the New Jersey DRG rates. The New Jersey Hospital Rate Setting Regulations, *see* N.J. Admin. Code, tit. 8, ch. 31B, § 3.73(a)(5) (Supp. 1990), required hospitals to include in their DRG rates billed to non-Medicare patients surcharges, averaging approximately 7% (34a), that were necessary to recoup shortfalls created by the difference between the Medicare rates of reimbursement and the New Jersey DRG rates (20a-21a; 68a).

c. Payor Discounts

Medicare was not the only preferred insurer. The State of New Jersey itself anointed others to receive "payor differentials" or rate discounts. Blue Cross was the prime beneficiary of the state's largesse, enjoying a whopping 11% discount because it offered open enrollment health insurance (21a; 68a).[3] Medicaid and Health Maintenance Organizations ("HMO's") also received favored treatment. Only commercial insurers and ERISA plans did not; indeed, they had to pay more in order to make up the shortfalls created by the privileged discounts.

3. Impact on ERISA Plans

The effect on ERISA plans and their beneficiaries of the surcharges required by the state-mandated cost-shifts was staggering. Less than 25% of the population of the State of New Jersey receives in-patient hospital care (37a). Based upon statistics supplied in the litigation by New Jersey's Assistant Commissioner of Health, the universe of hospital patients totalling approximately 1.2 million New Jersey residents each year included 900,000 non-payors whose treatment was financed by uncompensated care assessments. ERISA plan participants paid 40% of these uncompensated care costs, even though they comprised only 15% of the total hospital patient population — a substantial financial drain on ERISA plans, when annual uncompensated care costs were at the more than $700 million level and rising. The cost burden became

[3] Since federal law requires ERISA plans to limit their enrollment to covered employees and their dependents, *see infra* note 12, ERISA plans were foreclosed from eligibility for this open enrollment discount (68a-69a).

mind-boggling when the other cost-shifts were piled on, raising the tab for ERISA plans to as much as 40% of the more than $1.1 billion shortfall generated by the state-mandated cost-shifts (37a).

New Jersey's hospital rate-setting scheme was carefully fashioned not only to impose on ERISA plans and their beneficiaries the costs of uncompensated care, the Medicare shortfall, and the preferred-payor discounts but also to insure that ERISA plans could not escape the cost-shifts net. While ERISA plans were theoretically able to negotiate volume discounts with individual hospitals, no hospital in the state was willing to come to the negotiating table, since, as New Jersey's Assistant Commissioner of Health acknowledged, the New Jersey statute prohibited passing on to other patients any revenue shortfall caused by a digression from the state-mandated rates (43a). While uninsured patients were granted a right to appeal for a reduction of any excessive hospital bill whenever the DRG rates exceeded actual charges by more than $250 — an exceedingly efficacious right that resulted in a reduction to the lesser charges in 99% of the appeals (34a) — ERISA plans and their beneficiaries in a provision that expressly referred to "self-funded union [ERISA] plans" were denied this entitlement because of their plan coverage (78a).[4]

The New Jersey cost-shifting regime finally became unbearable. The average in-patient hospital benefits claim paid by Petitioner Welfare Fund in the State of New Jersey grew fourfold from $1,979.59 in 1987 to $7,990.96 in 1991. This dramatic and alarming increase could not be absorbed indefinitely out of the fixed annual level of employer contributions received by the Welfare Fund. Benefits had to be reduced, or other cost-savings realized; otherwise, the well would have run dry, and the Welfare Fund's 7,000 beneficiaries in New Jersey would have had to be added to the rolls of uninsured recipients of hospital care. Unlike other plans, which cut benefits or withheld payment of the surcharges in whole or in

[4] New Jersey's Patient Appeal Policy was classically Kafkaesque. "Self-funded union" plans were expressly ineligible to appeal (34a). ERISA plan beneficiaries also faced a no-win situation. They were ineligible if their "self-funded union [plan] does not reimburse the hospital on the DRG price per case" or if "the hospital bill has been paid in full by a third-party payer [ERISA plan] excluding the deductible." So long as a patient was an ERISA plan beneficiary, he lost his right to appeal, since he was ineligible both when his plan paid the full DRG charge and when it did not (69a). There was no other conceivable circumstance that could trigger eligibility. ERISA plans and their beneficiaries were locked in a Catch-22 bind.

part (69a), the Welfare Fund was forced to depart from its traditional self-administration system and retain the administrative services of Blue Cross. This arrangement enabled the Welfare Fund to share in the payor discount enjoyed by Blue Cross. The arrangement with Blue Cross was not limited to New Jersey. Blue Cross had to be selected to administer hospital benefits in all states in which the Welfare Fund's beneficiaries resided, since bifurcated administration would have been impracticable. Thus, apart from its devastating monetary impact, New Jersey's cost-shifting regime seriously disrupted the Welfare Fund's longstanding administrative practices not only in New Jersey but in other states as well.

C. Proceedings in the District Court

Petitioner Welfare Fund, a self-insured joint labor-management, multiemployer employee welfare benefit plan providing hospital and health benefits to longshore workers in the Port of New York and New Jersey, commenced a civil action under ERISA against two groups of defendants: the State Defendants and the Hospital Defendants.[5] The Welfare Fund sought an injunction prohibiting future enforcement by the State Defendants of the cost-shifts and also restitution from the Hospital Defendants of cost-shifts previously paid by the Welfare Fund on the grounds that the New Jersey statute was pre-empted by ERISA and worked an unconstitutional taking of property.[6] Other ERISA plans filed similar actions that were consolidated with the Welfare Fund's.

The district court entered summary judgment in favor of the Welfare Fund and the other ERISA plans on their pre-emption claim (94a). It held that the cost-shifting features of the New Jersey hospital rate-setting statute and regulations related to ERISA plans

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[5] The State Defendants were the New Jersey officials responsible for administering the challenged hospital rate-setting legislation (67a). The Hospital Defendants were virtually every acute-care hospital facility in New Jersey and their class representative, the New Jersey Hospital Association.

[6] Jurisdiction in the district court was predicated on ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) (1988), which empowers plan fiduciaries to bring a civil action to enjoin any act or practice that violates ERISA, to enforce any provision of ERISA, or to obtain appropriate equitable relief to redress any violation of ERISA (22a). Jurisdiction to entertain ERISA § 502(a)(3) actions resides exclusively in the district courts of the United States. *See* ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1) (1988). In light of the Welfare Fund's prosecution of this ERISA action and its constitutional challenge to the New Jersey statute, the district court was also vested with subject matter jurisdiction under 28 U.S.C. § 1331 (1988), which bestows on federal district courts original federal question jurisdiction of all civil actions arising under the Constitution, law, or treaties of the United States.

and, hence, were pre-empted by ERISA because these state-mandated cost-shifts:

- forced ERISA plans to structure their benefits in a particular manner (80a);
- subjected ERISA plans to inconsistent regulation (80a-81a);
- compelled ERISA plans either to disburse funds for the benefit of non-beneficiaries in contravention of the express proscriptions of ERISA or to reduce benefits to their own beneficiaries in contravention of the express provisions of their plan instruments (81a);
- subjected ERISA plans to ongoing administrative hardship (82a); and
- contained explicit references to ERISA plans (78a).

The district court denied the Taking Clause challenge on the grounds that (1) New Jersey did not use the cost-shifts to appropriate monies for its own use, (2) the cost-shifts benefitted ERISA plan participants by assuring the fiscal viability of hospitals in the state and providing a means by which ERISA plan participants themselves could receive quality health care whenever they could not afford it, and (3) the cost-shifts did not interfere with the reasonable investment-backed expectations of ERISA plans and their participants (89a-92a).[7]

D. Proceedings in the Court of Appeals

A panel of the United States Court of Appeals for the Third Circuit in a split decision reversed the district court's grant of summary judgment on the ERISA pre-emption claim and entered judgment in favor of respondents (23a-32a; 61a). The court of appeals

[7] The district court devoted only one page of its opinion to the Welfare Fund's restitution claim (66a). Despite noting ERISA as a basis for its subject matter jurisdiction (66a), the district court nevertheless recharacterized the restitution claim not as a federal ERISA claim, as alleged in the complaint, but as a state law claim which should be deferred to the New Jersey state courts in the interest of comity. Accordingly, the district court declined to exercise jurisdiction over what it labeled a state law claim (66a).

also affirmed the district court's rejection of the Taking Clause challenge (22a-23a).

The panel refused to credit Congress's straightforward declaration that a state law is pre-empted if it relates to an ERISA plan. In the majority's view mere relationship is insufficient to trigger pre-emption. Rather, the challenged state legislation must "relate to the plans in a way that *necessitates* pre-emption" (23a) (emphasis supplied).

While paying lip service to the test set forth in the statute, the panel majority actually undermines the express congressional intent. First, in the view of the court of appeals an express reference to ERISA plans in the New Jersey legislation can be disregarded for pre-emption purposes if its removal would not alter the legal effect of the statute (25a). Second, the majority opinion finds that Congress's only intention is to pre-empt those state laws that would result in inconsistent regulation in different states, a situation the panel majority found lacking in this case (24a-25a; 27a). Third, the majority limits the reach of the conspicuously broad ERISA pre-emption clause to those specific situations where courts have already found pre-emption (25a). The majority synthesizes existing caselaw to develop principles that in effect establish boundaries beyond which pre-emption would not extend (25a-26a). In its view a state law would relate to an ERISA plan only if a prior court decision had so found.[8]

[8] On June 15, 1993, the court of appeals denied applications for rehearing *en banc* (45a-46a). On July 8 the Third Circuit granted a Fed. R. App. P. 41(b) stay pending disposition of this petition.

REASONS FOR GRANTING THE WRIT

1. This Case, Which Involves the Effect of State Healthcare Regulations on ERISA Plans, Presents Substantial and Pressing Questions of National Scope and Importance.

This case is one of exceptional significance. It involves two areas of extreme national importance, healthcare and ERISA pre-emption. The inevitable interface between these two competing desiderata gives rise to issues that cry out for prompt resolution by the nation's highest Court.

Healthcare is the subject of increasing national attention and has been called the issue of the '90's. Whatever the future may hold at the federal level, healthcare regulation similar to New Jersey's is presently the subject of legislation in 36 states, and it is likely if present economic conditions continue that other states in the union will jump on the bandwagon.[9] If the decision of the court of appeals in this case is left undisturbed, these state billing schemes will spread, laying waste ERISA plans throughout the nation.

The integrity of the national policy favoring the creation and preservation of ERISA funds is in jeopardy. Congress, prompted by a desire to preserve and protect ERISA plans and to encourage and foster their creation, formulated in ERISA the most sweeping pre-emption provision possible. The history of that provision in this Court is the highest testimony to its national significance. Ten times in the last dozen years this Court has granted certiorari to review lower court determinations concerning ERISA pre-emption.[10] In ten decisions on the merits, only thrice has the Court failed to find that the challenged state law was pre-empted. The very number of times that this Court has visited the issue underscores its national importance.

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[9] 138 CONG. REC. S13267-02 (Sept. 10, 1992).

[10] *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. ____, 113 S. Ct. 580 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983); *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

This Court has repeatedly recognized the special significance of ERISA pre-emption by relaxing the usual norms for granting writs of certiorari in cases involving this issue. Often it has departed from the usual criterion of a conflict among the circuits and has granted review under the less rigorous standard of divisions, disagreements, or conflicts among lower federal or state courts. *See Ingersoll Rand,* 498 U.S. at 137; *Mackey,* 486 U.S. at 828; *Shaw,* 463 U.S. at 95. History teaches, then, that the importance of the ERISA pre-emption issue itself and this Court's role as protector of the congressional will are sufficient reasons for granting certiorari.

That enduring importance is present in this case with a vengeance because of the healthcare context in which the threat to ERISA plans arises. Hospital rate-setting focuses on a particular area in which ERISA plans are deeply involved. Hospital care is not some ancillary service or commodity that welfare plans purchase from time to time. It is their very *raison d'être.* ERISA welfare plans exist solely for the purpose of providing healthcare to their beneficiaries.[11] ERISA welfare plans and their participants exist in every state in this nation, and the problem of healthcare, especially for the indigent, is one of national scope. There can be no doubt, then, that the resolution of the issues in this case will affect ERISA plans throughout the country.

Despite this Court's repeated recognition of the sweep of ERISA pre-emption, the court of appeals in this case purports to find a fatal chink in the protective armor that Congress created, which puts at risk the lifeblood and very existence of ERISA plans. The Third Circuit's dangerous limitation on ERISA pre-emption in a manner that clearly departs from existing precedent warrants certiorari.

The court of appeals fashioned a novel and unprecedented test concerning the manner in which a state hospital rate-setting statute can be structured to extract from ERISA funds a disproportionate share of society's healthcare costs. This test threatens ERISA funds not only in New Jersey but throughout the nation.

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[11] Section 3(1) of ERISA defines an employee welfare benefit plan as including "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . ." 29 U.S.C. § 1002(1) (1988).

The decision here will go a long way toward limiting the vulnerability of ERISA plans to the appetites of state legislatures.

The breadth of the challenge to ERISA welfare plans by state healthcare regulation and hospital rate-setting is apparent when one considers the kinds of state laws that have triggered Supreme Court review in the past. These have included state garnishment statutes, *Mackey,* 486 U.S. at 826; motor vehicle financial responsibility laws, *FMC Corp,* 498 U.S. at 53; mandatory severance pay, *Fort Halifax,* 482 U.S. at 1; human rights laws, *Shaw,* 463 U.S. at 85; tax collection statutes, *Franchise Tax Bd.,* 463 U.S. at 1; and application of state common law tort and contract actions to ERISA plans, *Ingersoll Rand,* 498 U.S. at 135; *Pilot Life,* 481 U.S. at 42. It is safe to say that few, if any, of these laws, which the court has found worthy of its consideration, have the impact on or pose the threat to ERISA plans that is implicit in state healthcare and hospital rate-regulation.

The effect of the decision of the court of appeals will not be limited to New Jersey. If left to stand, it authorizes states to establish schemes that will divert hundreds of millions of dollars annually from the intended beneficiaries of ERISA plans and to treat ERISA payors differently from other hospital payors. Under the court of appeals decision states can mandate a healthcare scheme that creates a host of exemptions for virtually everyone but ERISA plans, leaving those plans holding the bag (42a-43a). If the court of appeals is correct, a state regulatory regime can be crafted deliberately to shift onto the plans the substantial costs of others.

In this case the plans were not merely hit; they were deliberately aimed at. The effect was not only to raise costs (by better than one-third) but also to subject the plans to the Hobson's choice of either reducing benefits to their own beneficiaries or violating ERISA by expending plan assets for the benefit of strangers.[12] The

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[12] Congress adopted in ERISA the requirement that "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." 29 U.S.C. § 1103(c)(1) (Supp. IV 1992). This mandate reaffirms for all ERISA plans the identical "exclusive benefit" requirements enacted by Congress as far back as 1947 in the Taft-Hartley Act for joint labor-management plans created in collective bargaining. *See* 29 U.S.C. § 186 (Supp. IV 1992). The "exclusive benefit" provisions prohibit the use of trust assets to benefit persons other than plan participants and their beneficiaries. *In re Typo-Publishers Outside Tape Fund,* 478 F.2d 374, 375-76 (2d Cir.), *cert. denied,* 414 U.S. 1002 (1973); *Blassie v. Kroger Co.,*345 F.2d 58, 68 (8th Cir. 1965).

decision as to whether states can continue their regulation of healthcare by forcing ERISA beneficiaries, contrary to Congress's mandate, to underwrite the care of others should be made by this Court.

The district court below toppled the rate-setting scheme that had been in existence in New Jersey for more than two decades. Indeed, the program relied so heavily upon ERISA plans to pay for indigent care that New Jersey conceded that its system was not viable without this exaction from ERISA plans (37a). When the district court held the cost-shift provisions unconstitutional, it inspired the New Jersey Legislature with the approbation and encouragement of the Governor to replace the existing collectivized rate-setting scheme with a free market system that went into effect on January 1, 1993 (22a).

Repeal of the challenged state legislation did not render the issues in this case moot. Apart from the practical need to decide these issues in order to resolve the restitution claims in this case (22a; 32a), reversal by the Third Circuit permits the New Jersey Legislature to reinstate the same or similar legislation. Moreover, the final decision in this case transcends the particular statute at issue; it will establish principles that will determine the contours of ERISA pre-emption in the healthcare field nationwide. Indeed, the effect of the lower court's adjudication was not confined to the State of New Jersey alone but reverberated in the halls of Congress. Senator Durenberger introduced a bill currently under consideration to remove state hospital rate-setting programs from ERISA's preemptive sweep. S. 3223, 102d Cong., 2d Sess. (1992), *reintroduced* as S. 480, 103d Cong., 1st Sess. (Mar. 2, 1993).

However, the nation does not have the luxury of awaiting rulings from courts in other states, *see, e. g., Travelers Ins. Co. v. Cuomo,* 813 F. Supp. 996 (S.D.N.Y. 1993), *appeal pending,* No. 93-7194 (2d Cir. argued May 20, 1993), or watching the outcome of the legislative process. The immense sums involved in these state-mandated programs require a prompt ruling from this Court for the good of all concerned.

The resolution of this question will affect every sector of the nation that provides health benefits to employees and their families through ERISA plans. Under the challenged scheme in New Jersey alone ERISA plan participants, who comprised 15% of hospital patients, were required to subsidize 40% of the $1.1 billion dollar shortfall generated by the state-mandated cost-shifts (37a). This

multi-million dollar charge reflected only one year's burden. Absent immediate correction by this Court, ERISA plans will be depleted as more and more states enact varying regulations designed to leech on to ERISA trust funds.

The need for a swift and decisive ruling by this Court is great no matter how the question is ultimately decided. Hospitals operating under state regulations are presently collecting millions of dollars annually from ERISA plans, as they did in New Jersey. If the plans prevail and the state schemes are held to be unconstitutional, the hospitals will have to make restitution of these monies at least for the period of the applicable statutes of limitations. *Harper v. Virginia Dep't of Taxation,* 61 U.S.L.W. 4664 (1993) (U.S. No. 91-794). The effect upon the hospitals will be devastating. It may, indeed, require state legislatures to bail out the healthcare institutions at tremendous cost to the taxpayers. The quality of healthcare in each state cannot fail to suffer. On the other hand, if ERISA plans are not permitted to apply the unconstitutionality ruling retroactively to recover the monies unlawfully collected from them, the plans will have lost tremendous sums under laws which should never have been passed and which in our jurisprudence are considered null and void. But the money will be gone nevertheless.

Prompt resolution is also called for because until this Court finally puts the issue to rest, ERISA plans will be reluctant to make the challenged payments. Confronted with the possibility that hospitals will be financially unable to pay back monies unlawfully collected or that retroactive recovery may be denied, the plans will prefer to withhold, or escrow, those portions of their beneficiaries' bills that constitute the illegal cost-shifts. This, of course, puts a financial strain on the hospitals, can lead to the denial of services to plan beneficiaries, and engenders wasteful litigation that the resources of both ERISA plans and hospitals can ill afford. The public weal demands an end to the upheaval and uncertainty that the decisions below have created.

There is also a very practical consideration to be factored into the equation. It is clear that so long as the circuit court's decision looms over their heads, employers and employees covered by ERISA plans will not passively sit by and continue to fund medical benefits for workers merely to permit states to siphon off the monies the contracting parties believed would be held in trust. Ironically, the decision below will cause the opposite of its intended effect by inducing those employers that are already providing welfare

benefits to reduce or eliminate those benefits in favor of wages or some other form of compensation that the workers can keep, thus aggravating the underlying healthcare crisis. As their past practices attest, employers and unions favor using available assets to create and fund welfare plans. In so doing they perform a real public service, consistent with the congressional purposes embodied in ERISA of fostering and encouraging these plans. But one cannot realistically expect these plans to accept the role of wet nurse to the rest of society in a scenario that they rightly believe constitutes an unconstitutional taking of their property. *See infra* pp. 21-24.

If the Third Circuit is to be reversed, it should be done posthaste so that the contracting parties do not have to restructure their arrangements.[13] Once altered, it is unlikely that these arrangements will be changed back in the wake of some future ruling. Similarly, if the Third Circuit's position is to be upheld, simple justice requires that it be done soon, so that management and labor can order their affairs accordingly. The present state of the law is in flux, and so the great usefulness of the law as a canon pursuant to which the private sector can order its affairs is absent. Too much is at stake — $400 million in New Jersey in one year alone — to warrant delay. This Court should grant certiorari and resolve the matter as soon as possible.

2. The Decision of the Court of Appeals, with its Constriction of ERISA Pre-emption so as to Permit State Taking of Plan Assets for Public Use, Conflicts with Applicable Decisions of This Court.

The bottom line of the Third Circuit's decision is to permit state legislatures to construct healthcare and hospital rate-setting systems which mandate the use of ERISA plan assets to fund medical care for non-beneficiaries. In the view of the court of appeals the inflation of hospital costs to plan beneficiaries by a factor of more than 35% has only a tenuous, remote, or peripheral connection with the plans and is not pre-empted so long as the statutory scheme is carefully crafted to make the targeting of ERISA plans sufficiently covert.[14] To salvage the New Jersey system the Third

[13] The current longshore collective bargaining agreements on the East Coast expire on September 30, 1994. Negotiations will commence in January 1994.

[14] Statistics confirmed by the Hospital Defendants reveal that in 1991 the surcharges to finance the mandated cost-shifts amounted to more than 35% of the average New Jersey hospital bill ($2,874 of surcharges included in an average bill of $8,196).

Circuit's decision at every turn runs afoul of prior decisions of this Court concerning not only ERISA pre-emption but also the Taking Clause of the Fifth Amendment. The New Jersey law did not merely relate to ERISA plans; it did so in a way that amounted to an unconstitutional taking of their property. Review by the Supreme Court is necessary to preserve a body of ERISA pre-emption precedent that has been built up over the past 12 years to effectuate the will of Congress and to shield ERISA plans from unconstitutional takings of their assets.

A. ERISA Pre-emption

There is inherent in the opinion of the court of appeals an invidious perversion of the very essence of the ERISA pre-emption doctrine. ERISA's pre-emption clause is clear and straightforward. State law is pre-empted if it relates to an ERISA plan in the ordinary, common sense meaning of those words, — if it has a connection with or reference to an ERISA plan. *Greater Wash. Bd. of Trade,* 113 S. Ct. at 583. The wealth of litigation engendered by this clause has been due not to any ambiguity or uncertainty in the statute but to a reluctance by the lower courts to give the congressional language its plain effect, a reluctance epitomized by the Third Circuit's metaphysical quest in this case to divine some deeper kind of relating that "necessitates" pre-emption (23a). The formulation by the court of appeals would permit courts to substitute their subjective judgment for the concrete touchstone enacted by Congress.

Although it acknowledged the test set forth in the ERISA statute and repeatedly articulated by this Court, the court of appeals chipped away at the express congressional intent. In its effort to avoid a relationship "that necessitates preemption" the circuit court engaged in some fancy analytical footwork. Unmindful of this Court's admonition that "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision," *Alessi,* 451 U.S. at 525, the Third Circuit transformed the "deliberately expansive" language chosen by Congress, *see Greater Wash. Bd. of Trade,* 113 S. Ct. at 583 (quoting *Pilot Life,* 481 U.S. at 46), into something crabbed and constricted.

The attorney for the state admitted that the New Jersey healthcare regime could not function without the participation of ERISA funds (35a). This candid admission was confirmed when,

in reaction to the decision of the district court that the cost-shifts could not constitutionally be imposed on ERISA plans, the New Jersey Legislature scrapped the entire system. Nevertheless, the majority of the panel of the court of appeals mischaracterized the mandated cost-shifts as a mere cost of doing business imposed by a law of general application, having too tenuous, remote, and peripheral a connection with ERISA plans to trigger pre-emption (23a; 26a-28a). The Third Circuit's error is not merely a matter of approach. Each of the bases for its decision conflicts with a prior decision of this Court.

First, the panel majority brushed aside the express reference to ERISA plans in the New Jersey legislation by asserting without any authority the proposition that the reference can be disregarded for pre-emption purposes if its removal would not alter the legal effect of the statute (25a-26a). This approach gratuitously creates an escape hatch previously unknown. This Court has never qualified its consistent holding that a statute that has a reference to an ERISA plan relates to that plan. *See Greater Wash. Bd. of Trade,* 113 S. Ct. at 583; *FMC Corp.*, 498 U.S. at 59-60; *Shaw,* 463 U.S. at 96-97.[15] Indeed, the precise argument made by the Third Circuit here, that a direct reference to ERISA plans may somehow be excused under certain circumstances and pre-emption avoided, was rejected by this Court in its latest ERISA pronouncement. *See Greater Wash. Bd. of Trade,* 113 S. Ct. at 583.

Second, the court of appeals purports to find that Congress's only intention was to pre-empt those state laws that would result in inconsistent regulation in different states, a result that declares open season upon ERISA plans that operate only in a single-state. The panel opinion quotes extensively from this Court's decision in *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1 (1987), in which that concern was mentioned (24a-25a).[16] However, to limit the congressional intent to this narrow field is manifestly unrealistic. Many ERISA plans operate only in a single state. It cannot be

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[15] Conspicuously absent from the majority decision is any analysis of the second prong of the "relate to" test. The majority does not come to grips with why the New Jersey system does not have a "connection with" ERISA plans. The dissent does not shy away from the controlling test and, applying it, easily finds the connection (37a; 39a; 43a-44a).

[16] The Supreme Court language quoted by the panel's majority is actually inapposite, since the Maine statute at issue in *Fort Halifax* called for the payment by employers of a one-time severance payment that did not implicate any ERISA plan.

seriously claimed that these single-state plans were not intended by Congress to enjoy the protections of ERISA pre-emption.

The congressional desire for uniformity must be taken as consistency *among* plans as well as *within* a plan. Congress intended that there be one, national standard governing ERISA plans and imposed pre-emption to prevent plans in one state from being treated differently from plans in another state. The Third Circuit's reading into ERISA pre-emption of a congressional purpose to thwart only inconsistent regulation of the same plan in different states is clearly contrary to the position of this Court, which has granted certiorari and found pre-emption where only single state plans were involved and inconsistent regulation was not at issue. *See Greater Wash. Bd. of Trade,* 113 S. Ct. at 588 (Stevens, J. dissenting) (dissent faults majority for pre-empting statute that poses no threat of inconsistent state regulation).

The third new limitation created by the circuit court is equally discordant with prior decisions of this Court. By developing principles that impose boundaries beyond which pre-emption will not extend, the circuit court's synthesis of existing caselaw circumscribes the conspicuously broad ERISA pre-emption clause to those specific situations where courts have already found pre-emption (25a-26a). In its view a state law would relate to an ERISA plan only if a prior court decision had so found. It is not a judicial function to erect fences where the legislature has not. Existing caselaw has hardly exhausted all the possible ways in which state statutes could relate to ERISA plans. To limit pre-emption to what has already been decided is to transform a extremely broad pre-emption provision into a very narrow one. The panel majority's approach parallels that of the Executive Branch, which had sought to define ERISA pre-emption by example or subject matter — an approach rejected by Congress. *See Shaw,* 463 U.S. at 98 n.19.

In contradistinction to the majority below the dissent stands as a model of common sense. Consistent with precedent it gives the term "relates to" its "ordinary and broad meaning"(44a). In so doing the dissent comes to the obvious conclusion that a statute which

- by express reference deprives ERISA plan beneficiaries of appeal rights enjoyed by others,
- by deliberate legislative structuring exempts a favored group of hospital payors

so as to shift their obligations onto ERISA plans,

- requires ERISA plans to devote more than one-third of their assets to fund healthcare for non-beneficiaries despite ERISA's express proscription,
- cannot function without the enforced participation of ERISA plans, and
- has quadrupled the average hospital bill for Welfare Fund beneficiaries

must relate to ERISA plans and so be pre-empted.

The majority decision which finds that a statute with these kinds of connections with ERISA plans does not relate to those plans must be tinkering with the concept of "relate to." The Third Circuit's niggardly reformation of the "relate to" test saps the pre-emption clause of all vitality in direct contradiction of consistent Supreme Court teaching. Such a radical departure should command the attention of this Court.

B. Unconstitutional Taking

No less deserving of the Court's attention is the fact that the cost-shifts mandated by the New Jersey hospital rate-setting scheme amount to an unconstitutional taking. The Taking Clause plays a significant role in this age of pervasive governmental regulation in limiting the government's power to debase the property rights and economic interests of its citizens through regulatory legislation. This Court has articulated three factors of "particular significance" in determining whether governmental regulation constitutes an invalid taking of property: (1) the character of the governmental action, (2) the economic impact of the regulation, and (3) the extent to which the regulation has interfered with investment-backed expectations. *Connolly v. Pension Benefit Guar. Corp.*, 475 U.S. 211, 224-25 (1986). The district court's analysis of these three factors (89a-92a), which was adopted by the court of appeals (22a-23a), in every respect contravenes prior decisions of this Court.

The lower courts in this case purported to see no problem because the State of New Jersey did not physically invade or permanently appropriate plan assets for its own use but merely "adjusts the benefits and burdens of economic life to promote the common good" (23a; 92a). This cavalier approach disregards the principle

established by this Court that a government regulation that goes too far will be just as violative of the Fifth Amendment as a direct taking. *Pennsylvania Coal Co. v. Mahon,* 260 U.S. 393, 415 (1922).[17]

The fundamental defect in the lower courts' analyses in this case is over-simplification of the character of the state action. That a state may never actually appropriate monies directly is inconsequential. The uncompensated care surcharges paid by ERISA plans and their participants are paid into a fund managed and controlled by a state bureaucracy. There is no doubt that the cost-shifting system is for a public use. Obviously, the State of New Jersey devised the system because of its perceived public benefit. Hospital care to the indigent and to the uninsured as well as the economic aid to the healthcare system provided by Medicare, Medicaid, Blue Cross, and HMO's presumably benefit the entire body politic.

Having established mandatory hospital care regardless of ability to pay, having compensated Blue Cross and other preferred payors for open-enrollment insurance and other systemwide benefits to the citizens of New Jersey, and having to make up the shortfalls created by the Medicare program, New Jersey had an obligation to assist the hospital industry to finance the costs of these public welfare programs. Lacking temerity to confront the public with the need for additional tax dollars to provide the state treasury with the funding required for these programs, New Jersey devised an elaborate cost-shifting scheme to have one segment of the populace underwrite the programs (35a). Under these circumstances the conclusion that there was no governmental appropriation is unrealistic and untenable.

The lower courts' analysis of the economic impact of the New Jersey system contravenes this Court's teaching that to pass muster under the Taking Clause, the state program must accord a compensatory benefit to those bearing the financial burden. *Norwood v. Baker,* 172 U.S. 269, 279 (1898) (any governmental exaction in excess of the special benefits accruing to the payor is an unconstitutional uncompensated taking). In short, there must be a

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[17] It would seem that at least with respect to part of the monies there was an actual invasion of the plans' assets. By requiring plans to pay uncompensated care taxes and then pocketing the matching federal funds, New Jersey actually took private monies for public use. The route from the plans' accounts to the state treasury may be circuitous, but it is direct, certain, and carefully plotted. Thus, despite the Third Circuit's disclaimer there is in this case a real, direct taking. With respect to all the assets the New Jersey scheme amounted to a regulatory taking, the sustaining of which by the Third Circuit contravenes prior decisions of this Court.

"reciprocity of advantage." *Meier v. Anderson*, 692 F. Supp. 546, 555 (E.D. Pa. 1988), *aff'd without op.*, 869 F.2d 590 (3d Cir. 1989).

The viability of the New Jersey hospital rate-setting scheme depended on its ability to milk ERISA plans (37a). There was no benefit to ERISA plans and their participants to compensate them for their role as public benefactors (43a). All that the district court could come up with is that the system assures the continued existence of hospitals from among which ERISA plan participants can choose and to which they can repair in the event they join the ranks of the indigent (92a). The court of appeals utterly failed to come to grips with the requirement of this Court that the benefit must be discrete and particular to the victim of the taking and not merely an indistinguishable share of the general benefit enjoyed by the public at large. The benefits to ERISA plan participants cited by the district court are no different than the benefits enjoyed by all other segments of society. It is difficult to imagine a state scheme that is a more perfect example of "forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole" — the very type of governmental action that the Taking Clause of the Fifth Amendment was designed to bar. *Armstrong v. United States*, 364 U.S. 40, 49 (1960).

Although it seems anomalous to discuss ERISA plans in terms of "investment-backed expectations," there is a consideration analogous to this factor. The employers' contributions to these plans and their employees' acceptance of those contributions in lieu of other expenditures in the wage/benefit package can certainly be likened to the investment of resources. The circuit court's evocation of "the historically heavy and constant regulation of health care in New Jersey" (23a) to sweep aside the interference with investment-backed expectations is obtuse indeed. ERISA itself establishes the regulatory expectation of plans and participants covered by the federal legislation, and that expectation is complete freedom from state interference. ERISA plans and their participants have more than a mere investment-backed expectation; they have a congressionally-created expectation that their plan assets would be protected from state predators.

Since the cost-shifting provisions of the New Jersey statute could not be anticipated by ERISA-protected plans and participants, do not confer on them any benefit not enjoyed by the general public, and impose the burden of social welfare programs on only one small segment of the state population, these provisions amount to

an unconstitutional taking in violation of the Fifth Amendment to the Constitution of the United States, as interpreted by this Court.

With respect, then, to both pre-emption and to the Taking Clause the Third Circuit's decision fails to adhere to the holdings and principles set forth by this Court. Review is warranted to correct these untoward departures.

CONCLUSION

This ERISA pre-emption case arises in the field of healthcare, an area of burgeoning state activity and a subject of important national concern. The Third Circuit's decision is antagonistic to the repeated holdings of this Court, drastically cuts back on the scope of ERISA pre-emption, and opens the door to state manipulation of employee welfare plans so as to require them to use a significant portion of plan assets to finance social programs for the benefit of non-beneficiaries. Under the tests enunciated by this Court the state laws at issue here do not merely have a connection with or reference to ERISA welfare plans, they relate to them in a way that amounts to an unconstitutional taking of property. A prompt resolution of these substantial issues by the Supreme Court is necessary to prevent untold harm to ERISA plans, hospitals, and state treasuries nationwide and to deter a cut-back in collectively bargained welfare benefits in derogation of the congressional purposes embodied in ERISA. For these reasons the petition for a writ of certiorari should be granted.

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